POLICIES AND PROCEDURES State of Tennessee Department of Intellectual and Developmental Disabilities	Policy #: 80.4.7	Page 1 of 11
	Effective Date: Pending	
	Distribution: B	
Policy Type: Community/Waiver	Supersedes: 80.4.7 (06/01/2012)	
Approved by: Debra K. Payne, Commissioner	Last Review or Revision: September 29, 2016	
Subject: RESIDENTIAL COMMUNITY TRANSITION		

I. **AUTHORITY:** Tennessee Code Annotated (TCA) Section 4-3-2701, TCA Section 4-3-2708, TCA Section 33-1-201, TCA Section 33-3-103, and TCA 66-28-501.

II. **PURPOSE:** The purpose of this policy is to clarify the residential community transition process requirements ~~process to transition from one provider of residential services to another or from one residential site to another~~ for people enrolled in ~~Department of Intellectual and Developmental Disabilities (DIDD)~~ one of the State's 1915(c) Home and Community Based Services (HCBS) Waivers or state-funded services.

III. **APPLICATION:** This policy applies to all DIDD staff, support coordination agencies, and contracted providers who may be involved in any community transition for people enrolled in ~~DIDD~~ Waiver or state-funded services.

IV. **DEFINITIONS:**

~~**Case Manager** shall mean an individual who assists the person in gaining access to needed Self-Determination Waiver and other Medicaid State Plan services as well as other needed services regardless of funding source; develops the initial interim Individual Support Plan and facilitates the development of the Individual Support Plan; monitors the person's needs and the provision of services included in the Individual Support Plan; monitors the person's budget, and authorizes alternative back-up services for the person, if necessary.~~

A. **Circle of Support (COS)** shall mean a group of people selected by the person supported who meet together on a regular basis to help a person supported plan for and accomplish his/her personal outcomes and actions. The person supported is the focus or the center of the COS. ~~At a minimum, this includes the person supported, his/her family member(s) and/or conservator(s), Independent Support Coordinator, Case Manager, and the providers of any supports and services that the person receives. Friends, advocates, and other non-paid supports are included at the invitation of the person.~~

B. **Community Transitions** shall mean the movement of a person supported from one residential service provider to another, from one residential setting to another residential setting, from one type of residential service to another type of residential service, or between regions.

C. **Community Transition Coordinator (CTC)** shall mean the Regional Office staff person who oversees the community transition process and ensures that transitions are implemented consistently and according to this policy.

D. **Home and Community Based Services (HCBS) Waiver or Waiver** shall mean a waiver program approved for Tennessee by the Centers for Medicare and Medicaid Services to provide services to a specified number of Medicaid eligible individuals who have an intellectual disability ~~(e.g. mental retardation)~~ and who meet criteria of Medicaid reimbursement of care in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). ~~the Intellectually Disabled.~~ The HCBS waivers for people with Intellectual Disabilities in Tennessee are operated by the DIDD ~~Department of Intellectual Disabilities~~ with oversight by TennCare, the state Medicaid agency.

E. **Independent Support Coordinator (ISC) or Case Manager** shall mean a person who provides support coordination services to a person supported and who is responsible for developing, monitoring and assuring the implementation of the Individual Support Plan (ISP) and ~~Plan of Care,~~ who assists the person supported in identifying, seeking, obtaining, coordinating and using both paid services and natural supports to enhance the person's independence, integration in the community and productivity as specified in the ISP.

F. **Individual Support Plan (ISP)** shall mean a person centered document that provides a comprehensive description of the person supported as well as guidance for how to accomplish unique outcomes that are important to the person in achieving a good quality of life in the setting in which the person chooses to reside.

G. **Natural Supports shall mean** family members and close (constant, stable, steady, long-lasting, and established) friends of the person supported. A natural support can be someone who is relatively new in the life of the person supported. Natural supports are not paid by DIDD or by contracted providers.

H. **Person Centered Planning** shall mean the process by which the ISP is developed to identify the needs and preferences of the person supported as described by the person, in collaboration with the COS so that the person may receive needed services and supports in the manner they prefer. The process is led by the person supported to the greatest extent possible or they are supported in leading this

process to the greatest extent possible. ~~which focuses on a person in terms of who they are, what they want in life, and how their desired outcomes may be accomplished. Based on the values of human rights, inter-dependence, social inclusion, and responsible choice, this process discovers the person's gifts, skills and capacities while balancing what is important to and important for the person now and in the future.~~

V. **POLICY:** This policy outlines a person-centered ~~planning~~ community transition process for ~~transitions of~~ people supported who are receiving Waiver or state-funded services. ~~from one DIDD service provider to another, from one residential home to another or from one grand region to another.~~ This process ~~should be~~ is led by the person to the fullest extent possible, with support from the Circle of Support (COS) in making sure the person's needs and preferences are met.

VI. **PROCEDURES:**

A. General Guidelines**:** Transition from any service provider initiated by the person or ~~Circle of Support (COS) or~~ legal representative ~~tion~~

1. All transitions must be person centered and in accordance with rules set forth by the Centers for Medicare and Medicaid Services (CMS).

2. The person supported has the right to choose services and providers as well as where and with whom he or she resides. The person supported leads the person centered planning process, to the fullest extent possible.

3. Moves for agency convenience are prohibited.

4. Solicitation of persons supported for the provider's benefit is not acceptable and is a violation of the Provider Agreement solicitation clause.

5. The Independent Support Coordinator (ISC) or Case Manager (CM) of the person supported is responsible for facilitating the transition, completing the Transition Planning Form, compiling documents to be included in the transition packet, and forwarding the entire packet to the respective DIDD Regional Office CTC.

6. A transition meeting is required for transitions, excluding emergency transitions, and must include the person and the COS. In case of a provider change, both providers need to be present either in person or by phone for the transition meeting. However, the person supported and or conservator may request that the ISC serve as the liaison and that either or both providers not attend the meeting, regardless of the reason for the transition.

~~The person supported has the right to choose services and providers as well as where and with whom he or she resides. The person supported leads the person centered planning process, where possible. This choice is to be provided even if the person has a legal conservator that typically makes those decisions.~~

~~a. Conservatorship papers shall may be requested and reviewed by the Regional Office Community Transition Coordinator (CTC). This review is to ensure that the conservator has the legal authority to pursue the transition, regardless of the person's wishes.~~

7. Contested Transitions

   a. If there is disagreement about the appropriateness of a proposed transition, the person or any member of the COS may contact the DIDD Regional Director or Complaints Coordinator to request assistance with conflict resolution (e.g. mediation).

   b. If the person supported expresses disagreement with a proposed transition, the transition plan must state the reasons for the disagreement and the reason the transition is being pursued without the person's agreement.

   c. The person's preferences should be considered even if the person has a legal conservator who typically makes those decisions. In their role as alternate decision maker, conservators or legal representatives may pursue contested transitions so long as it is being done in consideration of the person's desires and is in the person's best interest, not in lieu of the person. Conservatorship papers may be requested and reviewed by the Regional Office Community Transition Coordinator (CTC). This review is to ensure that the conservator has the legal authority to pursue or consent to the transition.

   d. The person supported and or conservator may request that the ISC serve as the liaison and that the provider not attend the meeting.

   ~~If there is disagreement among the COS members about the appropriateness of a proposed transition, any member of the COS may contact the DIDD Regional Director or Complaints Coordinator for conflict resolution or mediation.~~

8. The residential provider and the ISC have a shared responsibility to work with the person supported and the Circle of Support to complete a ~~shall be responsible for using~~ person centered matching tool to assist the person with staff and housemate selection, ~~and home selection~~ as applicable. The components listed at a through d apply to staff selection and c and d also

applies to the housemate. The matching tool should at least address the following for each person:

a. Supports wanted and needed
b. Skills needed
c. Personality Characteristics needed
d. Shared Common Interests

9. Current and emerging natural supports shall be identified as part of the transition plan and listed in the ISP so that the person supported does not lose touch with friends and family due to the transition.

10. When setting timeframes for the transition to occur, the COS should consider that transition plans must be submitted to the Regional Transition Unit fourteen (14) days prior to the expected move date to allow time for processing.

11. All residences must be properly inspected, licensed and certified, as applicable, prior to the person supported moving into the residence. Providers must abide by requirements for inspection, licensing, or any certification activities that must occur prior to occupancy if the person supported is moving from one home to another.

    a. Supported Living and Semi-Independent Living homes are required to pass a housing inspection prior to occupancy. These inspections are provided free of charge by DIDD Housing Inspectors. Providers should allow seven (7) business days from the date the request is submitted to the DIDD Central Office for the inspection to occur.

    b. Residential Habilitation homes require a license by DIDD Licensure.

    c. Family Model Residential settings ~~Services~~ require the provider agency to complete an Initial Site Assessment. ~~completed by the agency.~~

12. During transition planning the ISC/CM, along with the COS, shall determine ~~decide~~ if a therapeutic assessment is required using the Transition Planning Form.
    a. If the person has a community occupational therapist (OT) or physical therapist (PT), that therapist should be contacted to request that they complete the therapeutic site assessment.

b. If the person does not currently have a community OT or PT, the ISC/CM should make a referral to one for the therapeutic site assessment.

c. If a community therapist is not available, the ISC/CM shall make a referral to the appropriate Regional Therapeutic Services Team to request an assessment.

13. All homes must be physically accessible by the person supported who will reside in that home. Modifications that are essential to the person's accessibility and mobility must be in place prior to the move. ~~All recommended environmental modifications shall be in place and prior to the move unless otherwise indicated in writing. If environmental modifications cannot be completed prior to the actual move, a plan with timeframes for completion and for ensuring the person receives needed services and care shall be submitted to the Regional Office CTC as part of the transition packet. The plan must include a target date for completion of the modifications. The ISC/CM shall notify the Regional Office CTC when the modifications are completed.~~

14. When a transition occurs, both the sending and receiving provider are responsible for completing and submitting a Day of Move form to the ~~notifying the appropriate ISC~~ISC/CM for person's residing in the home ~~when a transition occurs~~ so that the ISPs ~~plans~~ of all persons residing at both the sending and receiving sites can be updated.

B. Exceptions to the Community Transition Process

1. Exceptions to the community transition process include moves from one residential setting to another as the result of unexpected circumstances requiring immediate relocation, but from which there is a reasonable expectation that person shall return to the original permanent location. Types of exceptions ~~emergency transitions~~ include, but are not necessarily limited to:

a. Removal from the Family Model home as a result of an investigation

b. Unplanned, significant home repairs

c. Natural disasters

2. These transitions require notification to the regional office and may require an ISP amendment and service authorization, but do not require a transition plan.

3. Environmental accessibility, housemate compatibility, and personal choice, must still be considered.

C. Inter-agency transitions initiated by person supported or conservator

1. A transition meeting is required for community transitions and includes the person supported and his/her chosen COS.

2. Both the sending and receiving agency shall be involved in all transition planning and have representatives present at all transition meetings.

3. The Transition Planning Form shall document how this transition shall better meet the needs of the person supported.

4. The transition packet shall be submitted to the Regional Office at least fourteen (14) calendar days in advance of the projected transition date and shall include at a minimum:

   a. An amended ISP, including the amended Section C with the name of the service providers, and the amount, frequency and duration of services

   b. Transition Planning Form

   c. Recommendations for staff cross training, if applicable.

5. Regional Office staff shall review the ISP in accordance with DIDD service authorization protocols and shall follow established procedures for approval or denial of service requests as well as issue written notice of the decision.

6. A copy of the person's complete comprehensive record for 12 months (including applicable releases of information) must be transferred to the receiving agency no later than the date of the transition in accordance with ~~Section A.19 of~~ the Provider Agreement.

7. If the person supported or legal representative declines participating in the transition meetings, the Regional Office shall be contacted for assistance with resolving any issues.

D. Changes Initiated by the Current Service Provider

1. If a service provider has determined that services shall be discontinued for a person supported, the provider shall comply with the Provider Manual

chapter 11 section pertaining to Lease Requirements Applicable to All Residential Services, the Provider Agreement between the State of Tennessee Department of Intellectual and Developmental Disabilities and the Bureau of TennCare (Provider Agreement), and the HCBS Settings Final Rule. ~~and a~~ An official notice of discontinuation of services must be issued.

2. The ISC/CM, Regional Office and legally responsible person shall work together to locate an alternative service provider for the person within sixty (60) calendar days of the issuance of the written notice.

3. Timeframes for completion of the transition must be developed as part of the plan and the Regional Office must be notified as soon as there is recognition that the transition cannot be accomplished by the original target date.

4. If this transition cannot be accomplished within that sixty (60) calendar day timeframe, the COS shall meet as soon as possible prior to expiration of the sixty (60) day timeframe to identify and address barriers to the transition. This meeting shall include a representative from the Regional Office.

5. The COS and the Regional Office are responsible to ensure that the transition occurs as soon as possible while simultaneously ensuring the person's health and welfare and choice of residence.

E. Transition of Residence or Residential Services: If a person receiving residential services is transitioning from one residential service provider to another but staying in the current home; staying with the same provider in the same home, but changing services; moving to a different residential home with the same provider; or to a different residential home with a different provider, the following procedures shall apply:

1. The COS shall ensure that the person is aware of and agrees with the transition even if the person has a conservator.

   a. If the transition has been precipitated by a dispute between the person supported and/or legal representative and the provider agency, the ISC/CM shall inform the DIDD complaint coordinator or Regional Office.

   b. A meeting shall be held with the person, ~~family,~~ conservator, and others selected by the person ~~the current service provider~~ to discuss and attempt to resolve any concerns regarding current services. This meeting shall include a representative from the Regional Office.

c. If these concerns cannot be resolved, the reasons must be thoroughly documented by the ICS/CM and submitted by the ISC/CM to the Regional Office as part of the transition packet.

2. The Transition Planning Form shall be completed by the ISC/CM.

3. Requirements regarding a change in providers as written in policy ~~P-008-B~~ 80.4.3 Personal Funds Management ~~Policy Section E.3. (h)~~ shall be completed, as applicable.

4. A personal budget shall be submitted indicating that the person supported can afford the on-going expenses associated with daily living in the new home. The COS shall determine how moving expenses shall be funded. This shall be documented on the Transition Planning Form.

5. All necessary equipment and medication shall be present and ready for use at the new location prior to or at the time of the person's arrival. ~~on the day of the move.~~

6. Any residence that shall be occupied by a person supported must meet all applicable occupancy requirements (e.g., licensure, fire safety, etc.) in accordance with DIDD Provider Manual Chapter on Residential Services prior to transition to the new residence.

7. A person supported shall remain in a rented or leased residence or room and board residential setting where a tenancy agreement is in effect until the terms of rental, lease, or tenancy agreement have been met. This requirement may be waived when:

   a. The provider agency initiating the transition is willing to accept responsibility for the payment of the remainder of the lease.

   b. The person supported has made arrangements for the payment of the remainder of the lease. If this arrangement involves an advance from a provider, there must be an approved agreement in place as required in ~~P- 008-B~~ policy 80.4.3 Personal Funds Management. ~~Policy.~~

   c. The person supported has received a notice of eviction.

   d. The lessor (e.g., landlord) is in default of the lease or rental agreement per Tenn. Code Ann. 66-28-501. ~~47-2A-508.~~

8. The sending and receiving service providers shall complete the applicable section of the Day of Move Notification of Community Transition form and

submit it to the Regional Office CTC by the first business day after the move.

9. If there is a change in residence, the ISC/CM shall ensure the next monthly visit occurs in the person's new home.

F~~.~~ Inter-region Transitions

1. When a person is transitioning from one grand region to another, the current ISC/CM shall notify the current region's CTC as soon as possible of the intended move.

2. The current CTC shall work with the CTC in the region of the anticipated move, the person supported, current ISC/CM, and COS to ensure an effective, efficient and person-centered planning process for the transition.

3. The current ISC/CM shall submit a transition plan for approval to the current CTC in accordance with this policy.

4. The current CTC shall review the transition plan and shall approve services according to service and rate approval protocols. The CTC shall ensure that all requirements in ~~P-008-B~~ policy 80.4.3 Personal Funds Management Policy ~~Section E.2.h~~ have been met.

5. The person supported may choose to remain with the current ISC agency or if the current ISC agency is not operating in the region of the anticipated move, the person shall ~~may~~ choose a new ISC agency. For persons receiving state case management services, a new Case Manager will be assigned who works in the region of the anticipated move. People supported may request a change in case manager at any time by contacting the DIDD Regional Office Director of Case Management.

6. If an ISC agency in the region of the anticipated move has not been chosen, the current CTC shall work with the person and legal representative to select a new ISC agency.

7. The new ISC/CM shall work with the person and legal representative to identify service providers in the region of the anticipated move.

8. The current CTC and the current ISC/CM are responsible for ensuring that copies of the person's records including cost plan information, ISP and other documents are forwarded to the CTC in the region of the anticipated move in

accordance with ~~Section A. 19 of~~ the Provider Agreement and the Provider Manual.

9. The CTC of the current region is responsible for ending services in that region upon completion of the transition.

VII. **CQL STANDARDS**: 2a, 2b, 4a, 4b, 8a

VIII. **REVISION HISTORY:** ~~September 10, 2015~~September 29, 2016

IX. **TENNCARE APPROVAL:** Pending

X. **ATTACHMENTS:**

~~Pre-Move Checklist: Home Site Assessment~~

A. Transition Planning Form

B. Day of t~~he~~ Move Notification of Community Transition~~ce~~